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Progress Through Partnership

Medicaid
Medicare
Management Institute

HEALTH CARE FINANCING ADMINISTRATION MARCH 1980 Issue # 3

CLEARINGHOUSE

MEDICAID MEDICARE EXCHANGE

HCFA's FIRST ANNUAL MEDICARE CONTRACTORS' CONFERENCE

Medicare contractor representatives from almost every State were among 250 attending the Medicare Contractors' Conference in Dallas, March 10 and 11.

The conference provided a forum for exchange of information and concerns between the contractor community and HCFA senior staff. A presentation by Under Secretary Nathan Stark focused on "Health Care in the 80's". HCFA Administrator Leonard D. Schaeffer presented HCFA's plans for improving health care information systems and the program operating framework.

Panels of contractor executives and HCFA senior staff addressed program initiatives, issues and techniques relating to competitive procurement of Medicare contracts, long-range challenges for health service delivery and financing, evaluating quality of health care and contractor performance, and improving services to beneficiaries.

Four papers which provide an overview of major HCFA initiatives impacting Medicare management were distributed: A policy statement on the Annual Hospital Report, and three discussion papers on Health Care Information Systems of the 80's, the Operating Framework for HCFA Program Administration, and HCFA Goals for Improving Consistency, Accuracy and Comparability of Diagnosis and Procedure Labeling Systems. Comments on the discussion papers are welcome. Copies may be obtained from the MMMI; contact Paul Beller, 301-594-8649, FTS 934-8649, or write: MMMI/HCFA, 389 East High Rise, Baltimore, Maryland 21235.

SAVING ENERGY MAY SAVE HOSPITAL COSTS

HCFA and Blue Cross of Greater Philadelphia are jointly funding the second phase of a several year model project designed to identify and evaluate capital projects in energy conservation for hospitals. In this phase, engineers will study energy consumption patterns in 59 hospitals and recommend the most cost effective measures for reducing energy use. Instituting recommendations (which may range from a major replacement of the entire heating system to a minor change in the burner unit) are expected to save over $4.5 million for the 59 institutions.

Project results should also reveal alternative strategies of reimbursement for capital investment in energy programs, and will indicate the level of financial support required initially by hospitals to implement the recommendations. Since HCFA programs finance nearly 40 percent of community hospital costs, energy savings of the magnitude projected here could have a major impact on HCFA hospital cost containment objectives. For further details contact Mike Hupfer, Office of Research, Demonstrations, and Statistics, 301-597-2375/6 or FTS 987-2375/6.

HCFA PROGRAM VALIDATION EFFORTS

Since its inception in June, 1979, HCFA's Office of Program Validation (Bureau of Quality Control) has completed 13 validation reviews, identifying over $1.5 million in program savings (including $1.4 million from five institutional studies and $124,000 from seven noninstitutional studies). Draft reports on 67 other validations, involving program savings of over $43 million (as of December, 1979) have been issued, but not finalized.

Purpose of the validation reviews (conducted both by Office of Program Validation teams, as well as teams operating out of the ten regional Offices of Program Integrity) is to minimize, through onsite reviews, opportunities for fraud, abuse, and waste in the Medicare and Medicaid programs resulting from: (a) improper practices on the part of health care providers; (b) failure of the Medicare and Medicaid claims payers to meet their operating responsibilities; (c) weaknesses in program policy and/or its implementation resulting in inappropriately paid funds; and (d) any combination of the above.

Representatives of the Office of Program Validation will meet with regional Office of Program Integrity Directors in Atlanta for a three day conference in April. The purpose of the conference is to discuss current projects, initiatives and legislation which are of mutual interest to both central and regional office components. Discussions will also include presentations on validation reviews and sanctions against providers who violate Medicare and Medicaid regulations. For further information on Office of Program Validation activities, contact Don Nicholson, Director, 301-594-8470 or FTS 934-8470.

BENEFICIARY SERVICES UNDERWAY

HCFA's Office of Beneficiary Services (OBS) is responsible for improving beneficiaries' understanding of the Medicare and Medicaid programs, and for increasing beneficiary involvement in these programs. Several beneficiary service initiatives are now underway at both central and regional levels.

The Office of Beneficiary Services conducted a Medigap training course for HCFA regional staff, January 29-30, 1980. In turn, regional staff will train volunteers nationwide to act as information sources for beneficiaries considering the purchase of private insurance to supplement Medicare. This State-by-State training is scheduled to begin in early May.

OBS is also conducting a national inventory of all HCFA components to obtain information about their beneficiary service activities. Regional staff will detail activities performed by intermediaries and carriers, State agencies, and Social Security offices. As a result, HCFA will be able to ensure the most efficient use of these resources, and determine the types of activities most effective in assisting Medicare and Medicaid beneficiaries. OBS will publish a "Beneficiary Guide to HCFA" this year, using the inventory results as a basis. For further information on OBS activities contact Barney Sellers, Director, 301-594-8131 or FTS 934-8131.

HCFA's Region VI (Dallas) staff recently coordinated a training program for the Arkansas Hospital Auxiliary Association to familiarize members with the Medicare and Medicaid programs, and other resources at community, State and Federal levels. In this first Statewide effort involving both programs, the hospital auxiliary members will advise Medicare and Medicaid patients and families about available services, answer general inquiries, and make appropriate referrals. For the training, this region published a booklet on the Medicare program and Arkansas' Medicaid program and produced a videotape describing the Arkansas Beneficiary Project. In addition, the regional office is developing a method to evaluate the impact of this initiative. Contact: Mary Ace, 214-767-6401 or FTS 729-6401.

As part of a joint HCFA/ACTION/RSVP effort, Region VIII (Denver) staff are involved in a demonstration project designed to develop a program of highly skilled service delivery through training volunteers to assist Medicare beneficiaries. This region's HCFA staff, along with staff from the Retired Senior Volunteer Program in Fort Collins, Colorado and Blue Shield of Colorado sponsored a three day training course in March for twenty RSVP volunteers to provide services to beneficiaries in Larimer County, (e.g., helping beneficiaries to understand program benefits, coverage, and to file claims and appeals). Staff expect ongoing RSVP services in Larimer County to continue beyond the one year demonstration period. Contact: Spencer Ericson, 303-837-2641 or FTS 327-2641.

Trainers... Take Note!

In the December issue of the MMX, the Medicaid/Medicare Management Institute offered to develop a national Medicaid trainers' directory. As we see it, this directory will include titles of manuals, publications, audio-visual materials and training programs that contributors are willing to make available to other trainers.

Medicare trainers thought this was a good idea, and suggested that we develop a similar directory for that program. Are you interested in being listed in either directory? Program areas of particular interest are: beneficiary and recipient services, financial management and reimbursement, provider relations, long term care, PSROs, utilization control, fraud and abuse control, third party liability, quality control, eligibility and enrollment.

In response to our earlier request, Sidney Sherman of New York State sent a list of programs which they are conducting for staff involved in auditing health care facilities. Their 1980 program calendar indicates they will be covering every major aspect of this topic. They invite anyone interested in observing their training to contact them at 518-473-4125.

If you would like to share the good things you are doing, please send us the following information: contact person, title, phone number, address, and type of Medicare or Medicaid training material you can make available to other trainers. Contributions are most welcome! Send material to Susan Eberhard, MMMI/HCFA, 389 East High Rise, Baltimore MD 21235, or call 301-594-8655, FTS 934-8655.

HCFA SECOND OPINION CAMPAIGN

To encourage Medicare and Medicaid beneficiaries and the general public to obtain a second opinion before undergoing non-emergency surgery, HCFA is conducting a nationwide information campaign. First year results of a three year HCFA demonstration by Blue Cross/Blue Shield of Greater New York show that in 31% of 1,464 cases recommended for surgery, the need for surgery was not confirmed by physician consultants. Blue Cross/Blue Shield of Michigan show similar first year results.

Radio and television announcements will highlight the campaign, as well as posters and brochures. A toll-free telephone hotline has been set up for patients to get names of physicians willing to give second opinions. The brochure, available in both English and Spanish, can be obtained by writing: Surgery, HEW, HCFA, Washington, D.C. 20201.

MEDIGAP PUBLICATION AVAILABLE

The Intergovernmental Health Policy Project offers health care managers a comprehensive picture of issues surrounding the sale of Medicare supplements in Medigap: State Responses to Problems with Health Insurance for the Elderly. According to the author of this 61 page publication, many States have taken regulatory action to curb Medigap abuses; however, most efforts have been limited in scope and do not yet provide the elderly with full protection. Summaries of specific State laws and regulations, and results from a survey of State insurance officials are included in the booklet. Copies are available at $5.00 from the Intergovernmental Health Policy Project, George Washington University, Suite 505, 1919 Pennsylvania Avenue, NW, Washington, D.C. 20006, telephone 202-872-1445.

UNIFORM DIAGNOSIS AND PROCEDURE LABELING

HCFA has instructed Medicare intermediaries to require providers that code diagnosis on Medicare billing forms to use the International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM), effective January 1, 1980. Similarly, carriers that now accept coding have been instructed to use this coding system, also effective January 1, 1980.

HCFA is also developing instructions for States and Medicare contractors to inform them that since ICD-9-CM is a statistical diagnostic coding system that uses up to five digits, all five digits should be reported to assure that diagnoses are accurately reported. This system, used in all settings where diagnostic information is required, has been implemented in such HEW financed programs as Medicare, Medicaid, the PSRO program, and the Cooperative Health Statistics System. The Commission on Professional and Hospital Activities (CPHA), the principal developers of ICD-9-CM, relinquished its copyright of the work on January 21, 1980. At the same time, CPHA reduced the price of their three volume ICD-9-CM publication. These manuals are available by writing directly to: ICD-9-CM, P.O. Box 991, Ann Arbor, MI 48106. To obtain code conversion tables and editing aids, call CPHA's toll-free number 800-521-6210, extension 355.

In another major effort, HCFA is working on a universal procedure labeling system based on Physicians Current Procedural Terminology - Fourth Edition (CPT-4), developed by the American Medical Association. CPT-4, already used by many physicians, contains the most comprehensive listing of terminology describing medical procedures and practices. Procedure information is primarily used in determining reimbursement for physician/supplier fees in the Medicare and Medicaid programs, and in conducting professional standards reviews. A technical advisory group of Medicare carrier, State Medicaid agency, and HCFA staff experts will recommend appropriate terminology and coding for nonphysician services fee reimbursement. In addition, South Carolina will serve as a test site for processing and reimbursement controls using CPT-4.

It is hoped that both the uniform diagnostic labeling system and uniform procedure labeling system will eliminate difficulties that competing systems have caused, and bring about a national data base for HCFA programs. No increase in the amount of reporting required or requested from the health care industry is intended; rather, HCFA's goal is to improve the consistency, accuracy and comparability of these key information elements needed to operate its programs.

REGULATION

Following are recent HCFA regulations of special interest to Medicare and Medicaid program managers. Questions may be directed to the contact person listed with each regulation.

HCFA; Statewide Professional Standards Review Council of New Jersey; Requests for Nominations for Public Member Positions on the Council - General Notice
12/12/79 Federal Register - Comments due 2/10/80
Contact: William Toby 212-264-4680

Medicare Program; Coverage of Oxygen for Use in a Patient's Home - Proposed Notice (see next entry)
12/14/79 Federal Register - Comments due 2/12/80
Contact: Henry J. Hehir 301-594-8561 or FTS 934-8561

Medicare Program; Coverage of Oxygen for Use in a Patient's Home - Proposed Notice, Extension of comment period.
2/22/80 Federal Register - Comments due 3/3/80
Contact: Henry J. Hehir 301-594-3830 or FTS 934-3830

HCFA; Professional Standards Review; Redesignation of PSRO Areas in California - Proposed Regulation
12/17/79 Federal Register - Comments due 2/15/80
Contact: Tony Culotta 301-594-4272 or FTS 934-4272

Medicare Program; Premium Rate for the Uninsured Aged - Final Notice
12/17/79 Federal Register - Effective 7/1/80
Contact: Guy King 301-594-2826 or FTS 934-2826

Medicaid Program; Medicaid Agency Fraud Detection and Investigation Program; Verification of Services - Proposed Regulation
12/21/79 Federal Register - Comments due 2/19/80
Contact: Irwin Cohen 301-594-8212 or FTS 934-8212

HCFA; Statement of Organization, Functions, and Delegations of Authority - General Notice (Office of Beneficiary Services)
12/21/79 Federal Register

HCFA; Monthly Adequate Actuarial Rates and Monthly Premium Rates - General Notice
12/31/79 Federal Register - Effective 7/1/80
Contact: Guy King 301-594-2826 or FTS 934-2826

HCFA; Statewide Professional Standards Review Council - General Notice
1/3/80 Federal Register - Comments due 3/3/80
Contact: J. D. Sconce 214-767-6427

HCFA; Clinical Laboratories; Personnel Standards; Reopening of Comment Period - Proposed Regulation
1/11/80 Federal Register - Comments due 2/11/80
Contact: Dr. Louis C. LaMotte 404-329-3824 or FTS 236-3824

HCFA; Pharmaceutical Reimbursement Board; Proposed MACs and Announcement of Public Hearings - Proposed Notice
1/21/80 Federal Register - Comments due 2/25/80
Contact: Charles Spalding 301-594-5403 or FTS 934-5403

HCFA; Fiscal Disallowance for Erroneous Payments in Aid to Families with Dependent Children and Medicaid Programs; Calculating Reduction in Federal Financial Participation for Incorrect Payment by States After September 1980 - Final Regulation
1/25/80 Federal Register - Effective 10/1/80
Contact: John Berry 301-597-1354 or FTS 987-1354

Medicaid Program; Quality Control System Error Rate - Final Regulation
1/25/80 Federal Register - Effective 1/25/80
Contact: John Berry 301-597-1354 or FTS 987-1354

Medicare Program; Cost Reporting Requirements for Home Health Agencies - Notice of Decision to Develop Regulation
1/29/80 Federal Register
Contact: Fred Koenig 301-594-8612 or FTS 934-8612

HCFA and OCSE; Assignment of Benefits; Collection of Medical Support and Payments - Final Regulation
2/11/80 Federal Register - Effective 5/12/80
Contact: Elizabeth Matheson 202-245-8097

Medicare Program; Provider Reimbursement Review Board - Proposed Regulation
2/14/80 Federal Register - Comments due 4/14/80
Contact: Stanley Katz 301-594-9595 or FTS 934-9595

HCFA; Pharmaceutical Reimbursement Board; Final Maximum Allowable Cost Determinations - Final Notice
2/14/80 Federal Register - Effective 3/31/80
Contact: Charles Spalding 301-594-5403 or FTS 934-5403

Medicare Program; Cost Reporting Requirements for Home Health Agencies - Proposed Regulation
2/15/80 Federal Register - Comments due 4/15/80
Contact: Fred Koenig 301-594-8612 or FTS 934-8612

Medicare and Medicaid Programs; Schedule of Limits on Home Health Agency Costs per Visit - Proposed Notice
2/15/80 Federal Register - Comments due 4/15/80
Contact: Carl Slutter 301-594-9344 or FTS 934-9344

SSA, HCFA, OHDS, OCSE; Automatic Data Processing Equipment and Services; Conditions for Federal Financial Participation - Final Regulation with comment period
2/19/80 Federal Register - Effective 2/19/80, comments due within 60 days
Contact: Joseph Strand 202-245-7488

HCFA; Imposition of Sanction on Health Care Practitioners and Providers of Health Care Services; Program Integrity - Final Regulation
2/20/80 Federal Register - Effective 2/20/80
Contact: Anthony J. Tirone 301-594-3642 or FTS 934-3642

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REGULATION REVIEW - continued

Medicaid Program; Payments for Long Term Care Facility Services - Final Regulation with request for additional comments
2/22/80 Federal Register - Effective 10/1/79, comments due 4/22/80
Contact: Carl Slutter 301-594-9344 or FTS 934-9344

PSRO; Review Responsibility and Authority of Professional Standards Review Organizations; PSRO Review of Intermediate Care Facilities if Medicaid State Agency Review is Ineffective or Inefficient - Final Regulation
2/22/80 Federal Register - Effective 2/22/80
Contact: Alan Reider 301-594-3980 or FTS 934-3980

HCFA; Health Financing Research and Demonstration Grants; Availability - Final Notice
2/25/80 Federal Register
Contact: Francis Lariviere 301-594-8274 or FTS 934-8274

Medicare Program; Payment for Services of Independent Rural Health Clinics - Final Regulation
2/28/80 Federal Register - Effective 3/1/80
Contact: Bernard Truffer 301-597-2584 or FTS 987-2584

Medicare and Medicaid Programs; Consolidation of Medicare and Medicaid Regulations for Survey and Certification of Health Care Facilities - Notice of Decision to Develop Regulations
2/29/80 Federal Register
Contact: Antoine J. Elias 301-594-7902 or FTS 934-7902

Medicare and Medicaid Programs; Utilization Review - Proposed Regulation
3/3/80 Federal Register - Comments due 5/2/80
Contact: Alan Reider 301-594-3980 or FTS 934-3980

Medicaid Program; Medicaid Management Information Systems - Final Regulation
3/5/80 Federal Register - Effective 4/4/80
Contact: Wesley Baker 301-594-1502 or FTS 934-1502

Medicare Program; Schedule of Target Reimbursement Rates for Institutions Furnishing Home Dialysis Supplies, Equipment and Support Services - Final Notice
3/5/80 Federal Register - Effective 1/1/80 through 12/31/80
Contact: Robert Niemann 301-594-6635 or FTS 934-6635

MMMI EVENTS

Carrier Representative Group Meeting
April 10, 1980 Baltimore, MD
Contact: Paul Beller
301-594-9523
FTS 934-9523

National MMIS Conference
April 14-16, 1980 Louisville, KY
Contact: Du'Va Clyburn
301-594-8648
FTS 934-8648

Annual Conference of State
Medicaid Directors
May 12-15, 1980 Memphis, TN
Contact: Ed Palder
301-594-8940
FTS 934-8940

Fiscal Intermediary Group Meeting
May 22, 1980 Baltimore, MD
Contact: Paul Beller
301-594-9523
FTS 934-9523

Independent Professional Review/
Medical Review Teams Workshop
June 3-5, 1980 Seattle, WA
Contact: Beulah Williamson
301-594-8647
FTS 934-8647

Workshop on Management Information
for Medicaid
June 18-19, 1980 Atlanta, GA
Contact: Beulah Williamson
301-594-8647
FTS 934-8647

Independent Professional Review/
Medical Review Teams Workshop
June 24-26, 1980 Chicago, IL
Contact: Beulah Williamson
301-594-8647
FTS 934-8647

PROVIDER AUDIT REPORT

Medicaid and Medicare managers concerned with provider audit and reimbursement may be interested in "Medicare Provider Audit Past, Present and Future." This 32 page staff paper, issued by HEW's Audit Agency (November 1979), traces the development of Medicare's provider audit system, describes its accomplishments and limitations, and looks at probable future developments. The paper also summarizes that system's cost effectiveness, HCFA's quality control efforts, and the GAO's approach to auditing providers. Also discussed are opportunities for the system's growth in the areas of fraud and abuse, operational audits, uniform accounting and reporting, and prospective reimbursement. To obtain single copies of this publication, contact Tom Cox, 301-594-7484 or FTS 934-7484.

REGION VII PUBLISHES BEST PRACTICES

Region VII has published a second report identifying good Medicaid management practices in several States in the region. These practices identified by State Medicaid Management Assessment Reviews between July 1, 1978 and June 30, 1979, cover all areas of program management. Copies of the report are available on request to:

William R. Blake, Jr.
Regional Medicaid Director
Health Care Financing Administration
601 E. 12th Street
Kansas City, MO 64106

ACTION TRANSMITTALS

These Action Transmittals have been issued by HCFA in recent weeks. States desiring copies may order them by calling 301-594-5519.

AT-79-107 Information Requested 12/4/79
Format/Reporting Requirements for Submitting MQC Data Tapes

AT-79-108 Program Instruction 12/12/79
Practitioners, Providers, or Other Health Care Suppliers Suspended, Excluded, or Terminated from the Medicare and Medicaid Programs.

AT-79-109 Program Instruction 12/14/79
Coding of Item H on the Medicaid Quality Control (MQC) Review Schedule

AT-79-110 Program Instruction 12/14/79
Sample Beneficiaries with More than One Open Medicaid Case; Death as an Unacceptable Reason for a Dropped MQC Review

AT-79-111 Reporting Requirement 12/17/79
Change of Mailing Address

AT-79-112 12/28/79
Addenda to Instructions for Completion of Revised Forms HCFA-120 and HCFA-2082

AT-80-1 Program Instruction 1/4/80
Practitioners, Providers, or Other Health Care Suppliers Suspended, Excluded, or Terminated from the Medicare and Medicaid Programs

AT-80-2 2/17/80
Title XIX, Social Security Act, Section 1903(g) -- Utilization Control (UC) Validation Survey for the Quarter Ending 12-31-79

AT-80-3 Program Instruction 1/30/80
Practitioners, Providers, or Other Health Care Suppliers Suspended, Excluded, Terminated from the Medicare and Medicaid Programs

AT-80-4 Regulation 1/25/80
(Refer to 42 CFR 431.801, 431.802) Title XIX; Quality Control System Error Rate

AT-80-5 Program Instruction 2/19/80
Request for Medicaid Quality Control Review Schedule Information for the July-December 1978 Review Period

AT-80-6 Regulation 2/11/80
(Refer to 42 CFR Parts 433, 435 and 436; 45 CFR Parts 302, 304, and 306) Title IV-D and Title XIX; Third Party Liability; Assignment of Benefits; Collection of Medical Support and Payments

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NORTHERN MARIANA ISLANDS

On January 2, 1980, Region IX approved the Medicaid State Plan for the Commonwealth of the Northern Mariana Islands, retroactive to April 1, 1979, bringing the total Medicaid programs to 54. The plan covers medical services to both categorically and medically needy recipients, and offers an additional 16 optional services. The Federal participation rate for the islands is 50% with a Federal ceiling of $900,000 per fiscal year. The Medicaid agency, directed by Gregorio S. Calvo, is located within the Department of Public Health and Environmental Services, headed by Carlos S. Camacho, Governor.

This group of volcanic islands, discovered by Magellan in 1521, was named after the Queen of Spain, Mariana of Austria, in 1667. The islands have since been occupied by Germany and Japan, and in 1944, liberated by the U.S. during World War II. The Northern Mariana Islands are part of the Micronesian Islands, all of which became a Trust Territory under a United Nations mandate after World War II. The islands' Commonwealth status, an important milestone in the dissolution of the trusteeship, was approved March 24, 1976 when P.L. 94-241 authorized Federal grant programs, "...as they apply to Guam."

The Northern Mariana Islands are located some 100 miles north of Guam; principal islands are Saipan, Rota, and Tinian. The language of the islands is English; also spoken is the original language, Chamorro, mixed with Filipino and Spanish. Current health care expenditures are roughly $2,500,000 (as of 12/78) with up to 20% of that amount going to off-island providers (e.g., to Guam, Hawaii, etc.). The main hospital and clinic for most outpatient services is the Dr. Torres Hospital in Saipan. Aside from tourism, the islands' economy is heavily dependent on local and Federal jobs; agriculture and fishing are confined to individual family efforts. In addition, Saipan is known for its sugar and cotton crops.

ACTION TRANSMITTALS - continued

AT-80-7 Plan Preprint 2/20/80
Preprinted State Plan Amendments on (1) Assignment of Rights to Medical Care Support and Payments as a Condition of Eligibility, and (2) Cooperative Arrangements with Other State Agencies for Enforcement of Rights to Support and Collection of Assigned Payments

AT-80-8 Program Instruction 2/26/80
Monthly Report on Suspensions, Exclusions, Terminations, Withdrawals, or Reinstatements of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services

Personnel

HCFA CHANGES

- Thomas M. Tierney was appointed Chairperson of the Provider Reimbursement Review Board, for a three year term, replacing Art Owens.
- Elsie Tytla, M.D. has left HCFA's Office of Professional and Scientific Affairs to join the Veterans' Administration.
- Judy Lave is the new director of HCFA's Office of Research, serving also as deputy director of the overall Office of Research, Demonstrations, and Statistics.
- Region III: Maurice Hartman is on detail as liaison to Federal Regional Council. In the interim, Alwyn Carty will serve as Regional Medicare Director, and Harvey Koster will serve as Regional Medicaid Director.

MEDICARE

The Intermediary-Carrier Directory (Revision 22) is now available and may be obtained by contacting the Distribution Liaison Officer, Room D-3, Gwynn Oak Building, 1710 Gwynn Oak Avenue, Baltimore, MD 21235. To order by telephone, call 301-594-5519, FTS 934-5519.

MEDICAID

New Medical Assistance Unit Directors

Mabel M. F. Chen - Guam
James C. Rogers - Kentucky
Adele Wilzack - Maryland
Gregorio S. Calvo - Northern Mariana Islands
Julio Cesar Galarce - Puerto Rico
Jeanette Mahoney - Virgin Islands

New Single State Agency Heads

William H. Whitehurst - District of Columbia
William L. Hussman - Kentucky
Carlos S. Camacho - Northern Mariana Islands
James Ellenbecker - South Dakota

Legislative Ledger

In the 96th Congress, the Senate Finance Committee and the House Ways and Means Committee resumed work on national health insurance. On February 21 and 25, the House Committee on Ways and Means, Subcommittee on Health, continued hearings on national health insurance and proposals to restructure incentives in the private health care sector. Attention focused on three current proposals: 1) Senator Kennedy's (D-MA) Health Care for All Americans Act, HR 5191; 2) Representative Ullman's (D-OR) Health Cost Restraint Act, HR 5740; and 3) Representative Martin's (R-NC) Medical Expense Protection Act, HR 6405.

On March 4, the full House Interstate and Foreign Commerce Committee approved the amendments to the Medicare and Medicaid laws (HR 3990 and HR 4000). The Committee added an amendment to HR 3990 which limits the discretionary power of the HEW Secretary to certify End Stage Renal Disease facilities. (This amendment requires the Secretary to certify ESRD facilities which have received a certificate of need from a State Health Planning and Development Agency.) The Committee also adopted amendments to HR 4000 which: 1) provide for a voluntary Medigap insurance policy certification program by HEW, similar to the program adopted by the Senate in the Disability Amendments (HR 3236); and 2) changes a previous amendment concerning second surgical opinions. Specifically, this requires consent of Medicare and Medicaid beneficiaries for mandatory second opinion demonstration projects.

On December 11, 1979, the House passed the Child Health Assurance Program bill (HR 4962). The Senate's version of CHAP (S 1209), approved earlier by its Finance Committee, should come up in the full Senate early in the session. During House debate of this bill, an amendment was added to limit Federal funding for abortions to cases where the life of the mother is endangered. Another amendment would permit individual States to further limit circumstances under which abortion funding would be available.

On January 31, the Senate passed the Social Security Disability Amendments of 1979 (HR 3236). This version of the bill includes a Medigap amendment, offered by Senators Baucus (D-MT) and Dole (R-KA), which limits the focus and Secretarial discretion with respect to setting standards for supplemental insurance policies to Medicare. Other provisions of the disability bill which affect the Medicare and Medicaid programs are discussed in the December, 1979 issue of the MMX.

The Senate also passed HR 2313 on February 7, authorizing FY 1980 and 1981 funds for Federal Trade Commission administered programs. Of special interest to Medicaid and Medicare managers is an amendment by Senator Lawton Chiles (D-FL) to allow the FTC to participate in a study with HEW on Medigap insurance. A House-Senate conference committee resumed in late March to work out differences in the versions passed by the two houses.

P.L. 96-173 was signed December 29, 1979. This law states that any person eligible for medical care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), who is a veteran with a service connected disability, may not be denied care and treatment for such disability under CHAMPUS solely because such person is eligible for care and treatment in Veterans' Administration facilities.

MEDICARE SYSTEMS TESTING

HCFA's Office of Methods and Systems (Bureau of Program Operations) completed 58 intermediary and carrier claims processing tests from October, 1979 through January, 1980. These tests indicate the efficiency of intermediary and carrier claims processing systems and identify areas for improvement.

Part A - Hospital Insurance - The Intermediary Systems Testing Project (ISTP) uses test claims containing Part A processing data. Intermediaries are required to process two separate test packages bi-annually. (Before 1980, the test was annual.) One package contains 352 claims, testing performance with required consistency edits. The intermediary independently processes these claims, then reports the results to its HCFA regional office for identification of needed corrective actions. The second package contains 118 claims, testing performance with entitlement, eligibility, and utilization data. Each intermediary must complete this package within eight weeks, sending results for central office evaluation. Central office then reports systems deficiencies for regional office determination of necessary corrective action.

The most common intermediary errors detected during the recent test period were: 1) charges not covered by Medicare; 2) payment of duplicate inpatient and outpatient claims; and 3) payment for overlapping service dates.

Part B - Medical Insurance - The Carrier Systems Testing Project (CSTP) is also performed bi-annually (before 1980, it was conducted annually) according to a predetermined testing schedule. Some 150 test claims are entered in a carrier's system over a four week period. Six weeks after test completion, central office reports to the appropriate HCFA regional office the errors detected and the carrier's test score. At regional office discretion, carriers failing to achieve a minimum score of 90 may be retested. Before 1980, retesting was mandatory with a minimum score of 85.

The most common carrier errors found during the report period were: 1) failure to state proper deductible on EOMBs; 2) excessive and duplicate queries; and 3) failure to follow physician profiles set by CSTP.

Response to ISTP and CSTP has been favorable from the involved regional offices, intermediaries, carriers, and central office components. For further information on systems testing, contact Jim Scarfo, 301-594-9801 or FTS 934-9801.

HEW AWARD TO HELP DISABLED LIVE INDEPENDENTLY

HEW's Rehabilitation Services Administration recently awarded $10 million to explore ways to help severely disabled persons live more independently, reducing the need for institutionalization. Ten State vocational rehabilitation agencies will establish Independent Living Centers offering counselling to assess the individual's needs, advocacy to assure the client receives entitled services, and assistance in locating accessible housing and transportation. Disabled persons will participate fully in making policy and decisions affecting Center operations.

HOSPICE DEMONSTRATION

Twenty-six hospice organizations that provide care for Medicare and Medicaid terminally ill patients will take part in a two year HCFA demonstration project beginning April, 1980. Under this project, HCFA will waive limitations that now prevent reimbursement for such home services as custodial care and providing pain controlling drugs. The 26 organizations were selected from 236 applications, and include 12 hospitals, 8 home health agencies, and 6 free-standing facilities. HCFA's Office of Direct Reimbursement in the Bureau of Support Services will serve as fiscal intermediary.

The Federal role in hospice care is further explained in "Hospice," an HEW public affairs pamphlet. Summarized are projects underway in HEW's Administration on Aging, Health Resources Administration, National Institute of Mental Health; and in the Veterans' Administration and ACTION, among others. The twelve page pamphlet defines the hospice, its range of services, and briefly discusses such surrounding issues as costs, reimbursement policies, training, and integration into existing health care delivery systems. Copies may be obtained by writing to the Hospice Office, HEW, Room 618C, Hubert H. Humphrey Bldg., Washington, D.C. 20201, or by calling 202-245-7698.

MEDICARE PREMIUMS TO INCREASE

The monthly Medicare Part B premium will increase 9.9 percent, from $8.70 to $9.60, effective July 1, due to higher health care costs. A notice of this increase was enclosed in all SSA benefit payments dated March 3, 1980. Beneficiaries who have their checks deposited directly in banks were notified via self-mailer in early March. In addition, a notice will be enclosed with the SMI quarterly premium bills mailed in March, April, and May.

The basic monthly premium for hospital insurance will increase from $69 to $78, effective July 1, 1980. This notice was enclosed with the combined SMI premium bills mailed in February.

The total cost of benefits under Part B are expected to increase from about $9.7 billion in FY 1980 to $11.4 billion in FY 1981. Enrollment in Part B should reach about 27.9 million persons in FY 1981, including 2.8 million disabled persons under 65 and 25.1 million 65 or older.

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JUSTICE DEPARTMENT FILES PROPOSED DECREE AGAINST SOUTH CAROLINA HEALTH CARE ASSOCIATION

February 7, 1980, the Department of Justice filed a proposed consent decree that would terminate its civil antitrust suit against the South Carolina Health Care Association, Inc., an association of nursing homes.

Attorney General Benjamin R. Civiletti said the proposed decree, which was filed in U.S. District Court in Columbia, South Carolina, will become final upon approval by the court. The civil suit was filed on August 27, 1979. It alleged that the defendant had violated Section 1 of the Sherman Act by conspiring to raise the price of nursing home services paid under the Medicaid program.

The proposed decree would enjoin the defendant from acting as an agent for its members in connection with any decision to accept or reject any terms of a Medicaid contract, reject or discharge Medicaid patients or threaten not to participate in the Medicaid program.

The decree would require that the defendant furnish a copy of the decree to each of its members and to set forth a written statement of its policy regarding compliance with the antitrust laws and the decree, and publish that policy in its newsletter at least once a year for three consecutive years.

In accordance with the Antitrust Procedures and Penalties Act of 1974, a competitive impact statement regarding the decree has been filed with the court. Copies of this statement and of the proposed decree are available on request to the Legal Procedure Unit, Room 7416, Department of Justice, Washington, D.C. 20530. Comments to the Department and to the Court regarding the decree should be directed to John W. Poole, Jr., Chief, Special Litigation Section, Antitrust Division, Department of Justice, Room 7216, Washington, D.C. 20530.

The Department's notice regarding this action is published in the February 21,1980 Federal Register.

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